

Workforce Development & Training

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Steering Committee Co-Chairs:
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STD/HIV Prevention Training Centers

August 2007

Today's Discussion

- ✦ Working concept of "training" & why it's fundamental to integration
- ✦ Background on National Network of STD/HIV Prevention Training Centers (NNPTC)
- ✦ Success in integrated efforts to train: interdisciplinary content; novel delivery methods (web-based); Ask-Screen-Intervene Curriculum
- ✦ Specific challenges to workforce development in the integration realm
 - ✦ Training on content, & training on how to integrate
- ✦ Culture of training needs to accommodate a shift from "disease" to "client"

Workforce Development and Training: Translating Research into Practice & Policy

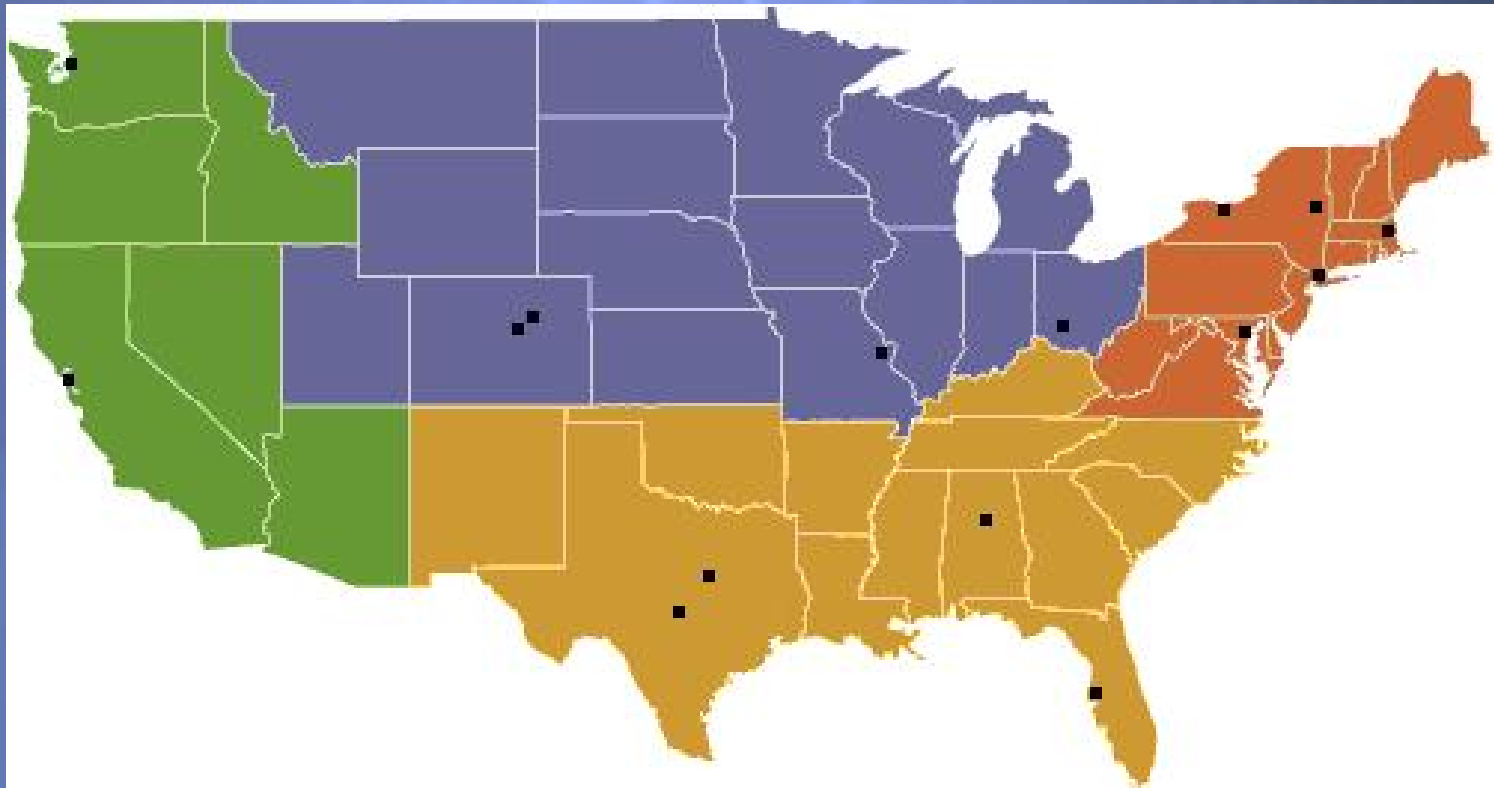
"Assuring a Competent Workforce"



Builds capacity to deliver services at
the client level!

An Example of Workforce Development Integration: The National Network of STD/HIV Prevention Training Centers

✦ 18 regional centers in network



www.stdhivpreventiontraining.org

NNPTC: 3 Parts

- ✦ Part 1: Clinical training on STD/HIV prevention, diagnosis, and treatment
 - ✦ Additional focus on viral hepatitis
 - ✦ Active collaboration with local TB training efforts
- ✦ Part 2: Behavioral training on STD/HIV prevention interventions (DEBI) and necessary foundational skills
- ✦ Part 3: Clinical and behavioral training related to partner counseling and referral services

www.stdhivpreventiontraining.org

The NNPTC Mission: The Text

- ✦ Dedicated to increasing the knowledge and skills of health professionals in the areas of **sexual and reproductive health**
- ✦ Provides health professionals with a spectrum of state-of-the-art educational opportunities, including **experiential** learning with an emphasis on **prevention**.

The NNPTC Mission: The Reality

Making & maintaining links between research, policy, and practice require an active training partner to help translate advances in these areas to effect change in practice

NNPTC Integrative Capacity Enhanced by Broad Expertise & Communication

★ Within NNPTC:

- ★ Combine clinical and educational expertise
- ★ Parts cross-pollinate for curriculum development
- ★ Ex: Development & teaching of viral hepatitis & HIV prevention curricula

CASE BASED MODULES

- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other hepatitis viruses
- Common management issues
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HEPATITIS WEB STUDY

This site provides interactive, case-based modules related to the clinical care of persons with viral hepatitis. Please choose a module to begin your self-assessment

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HIVWEB STUDY

Home | About This Site | Free CME | AETC NRC | Resources | Feedback | Site Map | New Cases

Case-Based Modules

- Initial Evaluation
- Dermatologic Manifestations
- Oral Manifestations
- OIs: Prophylaxis
- OIs: Treatment
- Antiretroviral Rx
- Antiretroviral Rx: Resistance
- Antiretroviral Rx: Adverse Effects
- Drug-Drug Interactions
- Postexposure Prophylaxis
- Perinatal Transmission
- Special Populations
- Prevention for Positives

This program is funded through Health Resources and Services Administration, US Department of Health and Human Services.

Prevention for Positives

Question | Discussion | References | CME Credit

Case 4: STDs and HIV Transmission

Authors: Emily Darby, MD
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Case last updated: September 7, 2006

A 23-year-old heterosexual HIV-infected woman presents to a sexually transmitted diseases (STD) clinic complaining of severe pain in her vulva. A sexual history reveals that she has had a steady HIV-negative sexual partner for 8 months, but occasionally exchanges sex for crack cocaine. She rarely uses condoms, explaining that she has heard it is difficult for women to transmit HIV to men. Her history and exam are consistent with primary genital herpes, and laboratory studies are sent to confirm this suspected diagnosis. She also undergoes complete testing for other common STDs.

Which of the following is TRUE regarding STDs and HIV transmission?

- A** The presence of genital lesions caused by HSV in an HIV-infected person confers a major increase (up to 4-fold) in the risk of HIV transmission to a HIV-negative partner.
- B** If this patient's HIV-negative sexual partner has a history of genital herpes, her current HSV infection would not place him at increased risk of acquiring HIV.
- C** Among sexually transmitted pathogens, only those organisms that cause genital ulcer disease are associated with an increased risk of HIV transmission.
- D** Treatment of common sexually transmitted infections that cause cervicitis, including chlamydia and trichomoniasis, in HIV-infected women has not been shown to decrease genital shedding of HIV.

www.hepwebstudy.org
www.hivwebstudy.org

NNPTC Contributions Are Enhanced by Strategic **External** Collaborations

- ✦ The “4TC” group: with AIDS Education Training Centers; Reproductive Health Training Centers; Addiction Technology Transfer Center
- ✦ State and Local Health Departments; Community Based Organizations; Professional Medical Organizations
- ✦ Joint meetings and strategic planning
 - ✦ Quadrant and center-wide advisory committees
- ✦ Development of uniform assessment instruments for joint training events

NNPTC Contributions Are Enhanced by HIV-STD Expertise

- ★ Training on
 - ★ Advancing HIV testing in medical care settings
 - ★ Rapid HIV testing, opt-out testing, and effective linkage to care and prevention program for persons newly diagnosed with HIV infection
 - ★ Partner management in HIV+
 - ★ STD-HIV interactions and role of primary HIV infection/STD coinfection as major player in HIV incidence
- ★ Development and diffusion of the national **Ask, Screen, Intervene (ASI)** training course, an integrated STD/HIV prevention curriculum to enhance prevention in HIV care settings

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV

Ask • Screen • Intervene

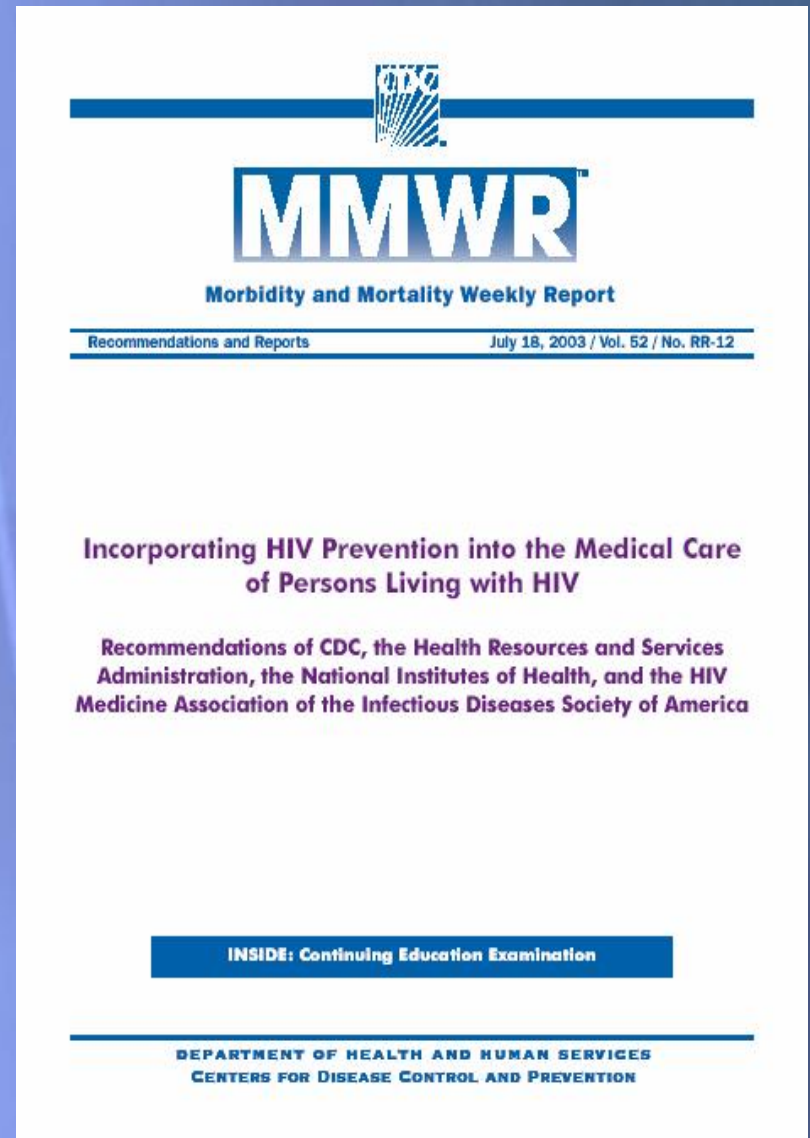
Developed by:

The National Network of STD/HIV
Prevention Training Centers, in conjunction
with the AIDS Education Training Centers



CDC Recommendations

- ★ Developed by CDC, HRSA, NIH, HIVMA, with evidence-based approach
- ★ Intended for those providing medical care to HIV-positive persons



(CDC. MMWR. 2003 July 18)

ASI Curriculum Content

- ✦ **Module 1:** Risk Screening: for Behavioral Risks and STDs
- ✦ **Module 2:** Universal Prevention Messages & Addressing Misconceptions
- ✦ **Module 3:** Tailored Behavioral Interventions
- ✦ **Module 4:** Partner Counseling & Referral Services

Ask, Screen, Intervene

Between May 2005 and March 2006:

- ✦ 52 regional training of other trainers
- ✦ Over 110 direct trainings
- ✦ Over 3,700 providers trained

Ask, Screen, Intervene: Collaboration among trainers

Collaborative effort within NNPTC:

- ✦ All 3 parts represented: Clinical, Behavioral, PCRS
- ✦ Included experts in science and experts in training

Collaborative effort with AETC:

- ✦ AETC actively involved in development
- ✦ Assisted directly with recruitment of faculty and course delivery

Collaborative effort with CDC:

- ✦ Active consultation with developers of guidance
- ✦ Direct involvement of training branch staff

Ask, Screen, Intervene:

Collaboration with medical professionals

Collaborative effort with HIVMA:

- ✦ “Prevention in Care” packets: all members
- ✦ IDSA Symposia – 2005, 2006, 2007

Collaborative effort with AAHIVM:

- ✦ Regional trainings
- ✦ Evaluation initiative

Collaboration locally with managed care organizations and private providers

ASI: Self-evaluation of Clinician Trainees

- ★ 84.7% found the information conveyed in ASI trainings useful to their practice (“somewhat high” or “very high”)
- ★ Simultaneous self-rating of skills demonstrated substantial improvements in knowledge and intention measuring items (for all items, $p < 0.001$):

	Ability to list elements of effective risk assessment for behaviors causing transmission of HIV/STD		Willingness to use clinic time to talk to HIV infected patients about reducing risks for HIV transmission		Ability to initiate discussion about sex partners and/or needle sharing partners	
	<i>Before</i>	<i>After</i>	<i>Before</i>	<i>After</i>	<i>Before</i>	<i>After</i>
N	409	408	384	379	293	289
Mean	3.29	4.37	3.72	4.40	3.51	4.36
Median	3.00	4.00	4.00	5.00	4.00	5.00

Integration that Worked!

ASI bridged:

- ✦ STD and HIV
- ✦ CDC and HRSA via NNPTC and AETC's
- ✦ Prevention and care
- ✦ Clinical & behavioral interventions
- ✦ Clinician & PCRS
- ✦ CDC funded training program and private medical societies
 - ✦ AAHIVM sponsorship of regional trainings
 - ✦ HIVMA/IDSA ongoing sponsorship of national trainings
 - ✦ HIVMA sponsorship of mailing of prevention in care package to private clinicians

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the client level!

Two Realms of Workforce Development and Training

- ★ Integrated training –
 - ★ Including aspects of HIV, TB, STD, Hepatitis in currently developed curricula and new courses yet to be developed
- ★ Training on integration –
 - ★ Building of integrated programs; Sharing of model practices; Technical assistance for program integration

Big picture training issues

- ✦ Different diseases, sites of practice, practitioners, and models of care
- ✦ Gap between science of HIV/TB/STD/Hepatitis and practice (efficacy to effectiveness)
 - ✦ Efficacious interventions may not always be effective in the real world if not translated with fidelity
- ✦ Some funding streams separate training & technical assistance
- ✦ Needs for basic program support training (program specific training alone may not be sufficient)
 - ✦ E.g. client-centered counseling, group facilitation, community assessment, and program evaluation

Outside input needed to support workforce development

- ✦ Need input from broad representation:
 - ✦ Researchers, training entities, and service providers (bridging efficacious with effective):
 - ✦ Clinical and behavioral scientists
 - ✦ HIV, STD, TB, hepatitis care providers
 - ✦ HIV/STD, TB, hepatitis, substance use, pregnancy prevention programs
 - ✦ Organizations representing PH, medical providers, etc (e.g. NCSD, NASTAD, HIVMA)
 - ✦ Correctional facilities
 - ✦ Immunization programs

Current training partners will need to further collaborate

- ✦ Establish stronger cross-fertilization within funded training partners regarding:
 - ✦ STD/TB/Hep screening considerations in HIV prevention training and various combinations including joint training
 - ✦ Behavioral interventions (esp. prevention counseling and group level interventions) in STD or other clinical settings
 - ✦ Expand beyond traditional target audiences
 - ✦ (Continued) focus on primary prevention: "We can't treat our way out of this epidemic"
- ✦ Encourage enhanced training collaborations with private and other sectors (e.g. corrections, managed care organizations, emergency departments, FQHC's, etc)

Training needed on integration itself

- ✦ Service providers and administrators will need
 - ✦ Technical assistance
 - ✦ Workforce sharing ideas
 - ✦ Help disseminating best practices or model examples
 - ✦ Basic understanding of other diseases they may need to educate or screen on
- ✦ Work force development requires increasing knowledge, but also shifting attitudes regarding prevention and care, clinical and behavioral “areas”

Culture of training may need to shift

- ✦ Where possible, integrate training and technical assistance activities.
- ✦ Increase formal communication among CDC programs and external training partners that conduct trainings:
 - ✦ Recognize that there are numerous entities that conduct training activities
 - ✦ Ensure consistent message delivery, reduce duplication of services, and streamline national coordination efforts
 - ✦ Consider advisory board involving key partners
- ✦ Pilot programs to highlight needed key collaborations

Structure of training may need to shift

- ✦ Develop a different structural approach in collaborating with organizations providing clinical and/or prevention services to enhance likelihood that training and capacity building efforts will result in measurable changes
 - ✦ Move from traditional focus on curricula-based training courses to addition of technical assistance services to increase program capacity building for integration
 - ✦ Continue to shift training to point of care
 - ✦ Take advantage of new technologies – web, etc

The great aim of education is
not knowledge, but action.

-Herbert Spencer